Goal B: Coordinated Medicaid Services

Objective: 01 Improve access to health care service for all eligible clients.

Outcome: 01 Percent of eligible clients receiving acute care services

Short Definition: Percent of eligible clients receiving acute care services

Purpose/Importance: Measures percent of eligible clients receiving acute care services

Source/Collection of Data: HCFA-2082 report. (In January of each year, the data is complete for the previous federal fiscal year.).

Method of Calculation: This measure is the percentage of the eligibles who actually receive acute care services, also referred to as the utilization rate. It indicates the annual unduplicated number of eligibles who actually received services divided by the annual unduplicated number of eligibles.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 – 01

Outcome: 02 Percent of 100% poverty population covered by acute care services

Short Definition: This measure is the percentage of people in Texas at or below 100% of the Federal Poverty Income Level (FPIL) that are covered by acute care services.

Purpose/Importance: This measure is the percentage of people in Texas at or below 100% of the Federal Poverty Income Level (FPIL) that are covered by acute care services.

Source/Collection of Data: RG-23 (MA007-01) & RG-24 (MS008-01) reports from the Premiums Payable System for recipient months. Poverty figures are derived from census survey data.

Method of Calculation: The percentage is derived from the average number of recipient months for which the premium payments are made divided by the estimated number of persons at or below 100% of the FPIL. When calculating the end of year figure, the average number of months is the sum of the monthly recipient month counts divided by the number of months summed.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 – 02

Outcome: 03 Percent of Medicaid clients eligible for Comprehensive Care Program (CCP) receiving services

Short Definition: This measure is the percentage of all Medicaid clients who are eligible for Comprehensive Care Program (CCP) services.

Purpose/Importance: This measure is the percentage of all Medicaid clients who are eligible for Comprehensive Care Program (CCP) services.

Source/Collection of Data: Source is the Premiums Payable System.

Method of Calculation: The percent is calculated by dividing the average number of child-related Medicaid recipient months by the average number of total Medicaid recipient months and express the result as a percentage. Recipient month averages are computed by summing the monthly recipient month counts and dividing by the number of months summed.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 – 03

Outcome: 04 Total Medicaid Recipient Months per Month

Short Definition: The Total Medicaid Recipient Months per Month is the average monthly number of recipient months (managed care and non-managed care combined) for which a premium payment is made for Medicaid recipients.

Purpose/Importance: The Total Medicaid Recipient Months per Month is the average monthly number of recipient months (managed care and non-managed care combined) for which a premium payment is made for Medicaid recipients.

Source/Collection of Data: Sources include the monthly RG-23 and RG-24 Premium Payable System Reports generated from the Texas Department of Human Services (TDHS) and Social Security Administration (SSA) eligibility files. Because data are reported on an incurral basis, recipient month figures are completed using completion ratios. The Health Care Financing (HFC) budget staff provides the HCF Budget Director with data used in computing measures. This information is reviewed by the HCF Budget Director prior to submission to the Bureau Chief and Associate Commissioner for HCF.

Method of Calculation: A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods. The quarterly average is the sum of the recipient months (managed care and non-managed care combined) for the three months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months (managed care and non-managed care combined) divided by the number of months summed.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 – 08

Outcome: 05 Total Average Monthly Premiums

Short Definition: The Total Average Monthly Cost (for managed care and non-managed care combined) is the amount paid to HMOs for each recipient month incurred plus the estimated cost of acute care services for the Primary Care Case Management (PCCM) and Fee-For-Service (FFS) models and reflects the cost of all covered Medicaid services. The monthly premiums for HMOs are determined by negotiations.

Purpose/Importance: The Total Average Monthly Cost (for managed care and non-managed care combined) is the amount paid to HMOs for each recipient month incurred plus the estimated cost of acute care services for the Primary Care Case Management (PCCM) and Fee-For-Service (FFS) models and reflects the cost of all covered Medicaid services. The monthly premiums for HMOs are determined by negotiations.

Source/Collection of Data: Data sources for this measures are the monthly ST-750 statistical reports compiled by the health insuring agent and the RG-23 and RG-24 Premium Payable System reports generated from the TDHS and SSA eligibility files. The Health Care Financing (HCF) budget staff provides the HCF Budget Director with data used in computing measures. This information is reviewed by the HCF Budget Director prior to submission to the Bureau Chief and Associate Commissioner for HCF.

Method of Calculation: For a quarterly or annual weighted average cost, sum the premium dollar amounts and recipient months for HMO members and add to that the average cost estimates and recipient months for the PCCM and FFS models for the given time period. The quarterly or annual weighted average cost is therefore equal to the total statewide dollar amounts for the time period divided by the total statewide recipient months for the time period. Recipient months are derived from the RG-23 and RG-24 Premium Payable System reports generated from the Texas Department of Human Services (TDHS) and Social Security Administration (SSA) eligibility files. For the more recent months of data, appropriate completion factors shall be applied in order to generate total incurrals. Cost estimates for the PCCM and FFS programs shall be based on statistical reports that depict claim cost and/or encounter information (the ST-750 reports furnished by NHIC).

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 – 09

Outcome: 06 Percent of pregnant Medicaid managed care members receiving a prenatal visit within 4 weeks of enrollment with a health plan

Short Definition: This measure describes the percentage of pregnant members receiving a prenatal visit within 4 weeks of enrolling in a health plan and describes the members' access to health care services.

Purpose/Importance: This measure describes the percentage of pregnant members receiving a prenatal visit within 4 weeks of enrolling in a health plan and describes the members' access to health care services.

Source/Collection of Data: The source for this measure is the plan submitted Performance Objectives. Each health plan submits this information on an annual basis.

Method of Calculation: This percentage is derived by dividing the number of Medicaid STAR eligibles in the pregnancy risk group receiving a prenatal visit within 4 weeks of enrollment with a health plan by the total number of Medicaid STAR eligibles in the pregnancy risk group who have been enrolled in a health plan for at least 4 weeks prior to the end of the reporting period.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: Yes

Desired Performance: Higher than target

Cross Reference to Prior Biennium: None

Outcome: 07 Total Medicaid managed care recipient months per month

Short Definition: This is the average monthly number of recipient months for which a premium payment is made for Medicaid STAR recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement.

Purpose/Importance: This is the average monthly number of recipient months for which a premium payment is made for Medicaid STAR recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement.

Source/Collection of Data: The source for this measure is the monthly eligibility file produced by the Medicaid Managed Care Enrollment Broker (Maximus).

Method of Calculation: The year to date average is the sum of the monthly recipient months divided by the number of months summed.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: Yes

Desired Performance: Lower than target

Cross Reference to Prior Biennium: None

Outcome: 08 Total Medicaid managed care cost savings per member per month

Short Definition: Total Medicaid managed care cost savings per member per month is the difference between Managed Care and Non-Managed Care Cost Per Member Per Month (PMPM).

Purpose/Importance: Total Medicaid managed care cost savings per member per month.

Source/Collection of Data: The source for this data is the HCFA 1915 (b) Waivers.

Method of Calculation: Total Medicaid Managed Care Cost Savings is the difference between Managed Care and Non-managed Care Cost Per Member Per Month (PMPM). Costs PMPM are calculated by dividing costs by eligible member months. Member months are the sum of all eligible months of each eligible member.

Medicaid STAR eligibles in the Disabled, Blind, Medically Needy, and Aged and Medicare Related risk groups are excluded from the calculations because the state does not pay an HMO premium for these members. Additionally, Vendor Drug costs for Temporary Assistance for Needy Families (TANF) are excluded because analyses indicate that drug costs are the same with or without managed care. Since directly comparable Non-managed Care costs are not available, these costs are estimated by projecting pre-managed care fee-for-service costs for members currently in Managed Care. These results are trended forward using statewide Medicaid historical trends.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: Yes

Desired Performance: Higher than target

Cross Reference to Prior Biennium: None

Outcome: 09 Percentage of Medicaid managed care member satisfaction with their health plan

Short Definition: This measure describes Medicaid STAR eligibles' overall satisfaction of their Health Plans. Members rate their health plans on a scale of 0 (least satisfied) to 10 (most satisfied).

Purpose/Importance: This measure describes Medicaid STAR eligibles' overall satisfaction of their Health Plans. Members rate their health plans on a scale of 0 (least satisfied) to 10 (most satisfied).

Source/Collection of Data: The source for this measure is the annual Consumer Satisfaction Survey administered by the Medicaid Managed Care Quality Monitor (Texas Health Quality Alliance). For this survey, the state's Quality Monitor employs the Consumer Assessment of Health Plan Survey (CAHPS) tool.

Method of Calculation: The number of responses for each rating is multiplied by the rating and summed. This weighted sum is then divided by the total number of responses to the survey and yields the percentage.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: Yes

Desired Performance: Higher than target

Cross Reference to Prior Biennium: None

Outcome: 10 Percent THS (EPSDT) eligible population screened-medical

Short Definition: Percent THS (EPSDT) eligible population screened-medical

Purpose/Importance: This measure reports the Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) clients served for children receiving medical screens, as calculated using the HCFA-416 methodology.

Source/Collection of Data: The data source is HMPR980K generated by (National Heritage Insurance Company (NHIC) and/or utilization management data provided by the TDH Bureau of Medicaid Managed Care.

Method of Calculation: The calculation is the result of dividing the number of THSteps eligible children receiving at least one initial or periodic medical screening service by the number of THSteps children who should receive at least one initial or periodic medical screening service. The number of THSteps eligible children receiving at least one initial or periodic medical screening service is the unduplicated count of individuals who received one or more documented initial or periodic medical screening services during the state fiscal year. The number of THSteps eligible children in each of six age groups (i.e., <1, 1-2, 3-5, 6-9, 10-14, 15-20) who should receive at least one initial or periodic medical screening service is the average period of eligibility in that age group multiplied by the recommended number of screens, or one, whichever is less. That number is then multiplied by the number of screens of THSteps eligible children in the age group. The six age group numbers are then summed.

Data Limitations: Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

Cross Reference to Prior Biennium: AGY 501 076 - R 04 - 02 - 01

Outcome: 11 Percent of THS (EPSDT) eligible population served – dental

Short Definition: Reports the annual THS (EPSDT) dental client participation.

Purpose/Importance: This measure reports the annual THS (EPSDT) dental client participation.

Source/Collection of Data: HMPR980K generated by the Texas Department of Health Insurance Contractor (National Heritage Insurance Company Report).

Method of Calculation: The calculation is the result of dividing the number of THSteps eligible children receiving at least one dental service by the number of THSteps children who should receive at least one dental service. The number of THSteps eligible dental children receiving at least one dental service is the unduplicated count of individuals who received one or more documented dental services during the state fiscal year. The number of THSteps dental eligible children in each of three age groups (1-5, 6-14, 15-20) who should receive at least one dental service is the average period of eligibility in that age group. That number is then multiplied by the number of THSteps dental eligible children in the age group. The three age group numbers are then summed.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

Cross Reference to Prior Biennium: AGY 501 076 - R 04 - 02 - 02

Strategy: 02-01-01 Premiums: Aged and Disabled

Efficiency: 01 Average Aged and Medicare Related Premium per Recipient Month: Managed Care

Short Definition: This is the average monthly premium paid per aged and Medicare managed care recipient month.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: Monthly ST750 statistical report compiled by the health insuring agent and the RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 01 EF 01

Efficiency: 02 Average Aged and Medicare Related Premium per Recipient Month: Non-Managed Care

Short Definition: This is the average monthly premium paid per aged and Medicare related, non-managed care recipient month.

Purpose/Importance: This measure reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST-750 statistical report compiled by the health insuring agent and the RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client, and dividing the total by the number of projected recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 01 EF 02

Efficiency: 03 Average Disabled and Blind Premiums per Recipient Month: Managed Care

Short Definition: This measure is the average monthly premium paid per disabled and blind, managed care recipient month.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST750 statistical report compiled by the health insuring agent and the RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 01 EF 03

Efficiency: 04 Average Disabled and Blind Premium per Recipient Month: Non-Managed Care

Short Definition: The average monthly premium paid per disabled and blind, non-managed care recipient month.

Purpose/Importance: This measure reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST-750 statistical report compiled by the health insuring agent and the RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 01 EF 04

Output: 01 Average Aged and Medicare Related Recipient Months per Month: Managed Care

Short Definition: The average monthly number of recipient months for which a premium payment is made for aged and Medicare, managed care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months for which a premium payment is made for aged and Medicare, managed care recipients.

Source/Collection of Data: The RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 01 OP 01

Output: 02 Average Aged and Medicare Related Recipient Months per Month: Non-Managed Care

Short Definition: The average monthly number of recipient months for which a premium payment is made for aged and Medicare related non-managed care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months for which a premium payment is made for aged and Medicare related non-managed care recipients.

Source/Collection of Data: The monthly RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 01 OP 02

Output: 03 Average Disabled and Blind Recipient Months per Month: Managed Care

Short Definition: The average monthly number of recipient months for which a premium payment is made for aged and Medicare related non-managed care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months for which a premium payment is made for aged and Medicare related non-managed care recipients.

Source/Collection of Data: The RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 01 OP 03

Output: 04 Average Disabled and Blind Recipient Months per Month: Non-Managed Care

Short Definition: The average monthly number of recipient months of eligibility for which a premium payment is made for disabled and blind non-managed care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months of eligibility for which a premium payment is made for disabled and blind non-managed care recipients.

Source/Collection of Data: The monthly RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: The average monthly number of recipient months of eligibility for which a premium payment is made for disabled and blind non-managed care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement. Recipient months are accounted for under an incurred basis and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 01 OP 04

Strategy: 02-01-02 Premiums: TANF (AFDC) Families

Efficiency: 01 Average TANF Adult Premium per Recipient Month: Managed Care

Short Definition: This measure is the average monthly premium paid per TANF-related adult, managed care recipient month.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST750 statistical report compiled by the health insuring agent and the RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 02 EF 01

Efficiency: 02 Average TANF Adult Premium per Recipient Month: Non-Managed Care

Short Definition: This measure is the average monthly premium paid per TANF-adult, non- managed care recipient month.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST-750 statistical report compiled by the health insuring agent and the RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: The average monthly premiums calculated by taking the total estimated dollar value of claims to be incurred for each type of client and dividing the total by the number of recipient months to be incurred.

Data Limitations: Providers generally have up to 95 days after the date of service to submit a claim for payment. Therefore, the count of actual claims incurred for each type of client is not completed until the following fiscal year.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 02 EF 02

Efficiency: 03 Average TANF Children Premium per Recipient Month: Managed Care

Short Definition: This measure is the average monthly premium paid per TANF-related children, managed care recipient month.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST750 statistical report compiled by the health insuring agent and the RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 02 EF 03

Efficiency: 04 Average TANF Children Premium per Recipient Month: Non-Managed Care

Short Definition: This measure is the average monthly premium paid per TANF-related children, non-managed care recipient month.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST-750 statistical report compiled by the health insuring agent and the RG-23 and RG-24 reports from Premiums Payable System.

Method of Calculation: The calculation is made by taking the total dollar value of claims to be incurred for each type of client and dividing the total by the number of recipient months to be incurred.

Data Limitations: Providers generally have up to 95 days after the date of service provided to submit a claim for payment. Therefore, the count of actual claims incurred for each type of client is not completed until the following fiscal year.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 02 EF 04

Strategy: 02-01-02 Premiums: TANF (AFDC) Families

Output: 01 Average TANF Adult Recipient Months per Month: Managed Care

Short Definition: The average monthly number of recipient months for which a premium payment is made for TANF-related adult, managed care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months for which a premium payment is made for TANF-related adult, managed care recipients.

Source/Collection of Data: The RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 02 OP 01

Strategy: 02-01-02 Premiums: TANF (AFDC) Families

Output: 02 Average TANF Adult Recipient Months per Month: Non-Managed Care

Short Definition: The average monthly number of recipient months of eligibility for which a premium payment is made for non-managed care, TANF-related adults.

Purpose/Importance: Measures the average monthly number of recipient months of eligibility for which a premium payment is made for non-managed care, TANF-related adults.

Source/Collection of Data: The monthly RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under an incurred basis, and the exposure period for each month is the current plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 02 OP 02

Output: 03 Average TANF Children Recipient Months per Month: Managed Care

Short Definition: The average monthly number of recipient months for which a premium payment is made for TANF-related children, managed care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement.

Purpose/Importance: The average monthly number of recipient months for which a premium payment is made for TANF-related children, managed care recipients.

Source/Collection of Data: The RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 02 OP 03

Output: 04 Average TANF Children Recipient Months per Month: Non-Managed Care

Short Definition: The average monthly number of recipient months of eligibility for which a premium payment is made for non-managed care, TANF-related children. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months of eligibility for which a premium payment is made for non-managed care, TANF-related children.

Source/Collection of Data: The monthly RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement. Recipient months are accounted for under an incurred basis and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 02 OP 04

Strategy: 02-01-03 Premiums: Pregnant Women

Efficiency: 01 Average Pregnant Women Premium per Recipient Month: Managed Care

Short Definition: This measure is the average monthly premium paid per pregnant women, managed care recipient month.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST750 statistical report compiled by the health insuring agent and the RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 03 EF 01

Efficiency: 02 Average Pregnant Women Premium per Recipient Month: Non-Managed Care

Short Definition: This measure is the average monthly premium paid per pregnant women, non-managed care recipient month.

Purpose/Importance: This measure reflects the average amount paid to the health insuring agent for each service covered under the insured arrangement.

Source/Collection of Data: The monthly ST-750 statistical report compiled by the health insuring agent and the RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims to be incurred for each type of client and dividing the total by the number of recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 03 EF 02

Output: 01 Average Pregnant Women Recipient Months per Month: Managed Care

Short Definition: The average monthly number of recipient months for which a premium payment is made for pregnant women, managed care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months for which a premium payment is made for pregnant women, managed care recipients.

Source/Collection of Data: The RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement. Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 03 OP 01

Output: 02 Average Pregnant Women Recipient Months per Month: Non-Managed Care

Short Definition: The average monthly number of recipient months of eligibility for which a premium payment is made for eligible non-managed care, pregnant women. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement.

Purpose/Importance: Measures The average monthly number of recipient months of eligibility for which a premium payment is made for eligible non-managed care, pregnant women.

Source/Collection of Data: The monthly RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement. Recipient months are accounted for under an incurred basis and the exposure period for each month is the current month plus an additional seven months to allow for corrections, redeterminations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 03 OP 02

Strategy: 02-01-04 Premiums: Children/Medically Needy

Efficiency: 01 Average Newborn Premium Per Recipient Month: Managed Care

Short Definition: This measure is the average monthly premium paid per newborn, managed care recipient month. It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST750 statistical report compiled by the health insuring agent and the RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative.

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 EF 01

Efficiency: 02 Average Newborn Premium Per Recipient Month: Non-Managed Care

Short Definition: The average monthly premium paid per newborn infants, non-managed care recipient month. This measure reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated costs of all services covered under the insured arrangement.

Purpose/Importance: This measure reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated costs of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST-750 statistical report compiled by the health insuring agent and RG-23 & RG-24 reports from the Premium Payable System.

Method of Calculation: The average monthly premium is calculated by taking total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative.

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 EF 02

Efficiency: 03 Average Expansion Children Premium Per Recipient Month: Managed Care

Short Definition: This measure is the average monthly premium paid per expansion children, managed care recipient month. This measure reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated costs of all services covered under the insured arrangement.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST750 statistical report compiled by the health insuring agent and the RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 EF 03

Efficiency: 04 Average Expansion Children Premium Per Recipient Month: Non-Managed Care

Short Definition: This measure is the average monthly premium paid per expansion children, non-managed care recipient month.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST-750 statistical report compiled by the health insuring agent and the RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: The calculation is made by taking the total estimated dollar value of claims to be incurred for each type of client and dividing the total by the number of recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 EF 04

Efficiency: 05 Average Federal Mandate Children Premium Per Recipient Month: Managed Care

Short Definition: This measure is the average monthly premium paid per federal mandate children, managed care recipient month. It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST750 statistical report compiled by the health insuring agent and the RG23 and RG24 reports from the Premium Payable System.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 EF 05

Efficiency: 06 Average Federal Mandate Children Premium Per Recipient Month: Non-Managed Care

Short Definition: This measure is the average monthly premium paid per federal mandate children, non-managed care recipient month. It reflects the amount paid to the health insuring agent for each recipient month incurred and the estimated cost of all services covered under the insured arrangement.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST-750 statistical report compiled by the health insuring agent and the RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: The calculation is made by taking the total estimated dollar value of claims to be incurred for each type of client and dividing the total by the number of recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 EF 06

Efficiency: 07 Average Medically Needy Premium Per Recipient Month: Managed Care

Short Definition: This measure is the average monthly premium paid per medically needy, managed care recipient month. It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST-750 statistical report compiled by the health insuring agent and the RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 EF 07

Efficiency: 08 Average Medically Needy Premium Per Recipient Month: Non-Managed Care

Short Definition: The average monthly premium paid per medically needy, non-managed care recipient month. This measure reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated costs of all services covered under the insured arrangement.

Purpose/Importance: This measure reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated costs of all services covered under the insured arrangement.

Source/Collection of Data: The monthly ST-750 statistical report compiled by the health insuring agent and the RG23 and RG 24 reports from the Premiums Payable System.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected recipient months to be incurred.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 EF 08

Efficiency: 09 Average Children's Health Insurance Premium Per Recipient Month: Managed Care

Short Definition: This measures is the average monthly premium paid per Children's Health Insurance Program Managed Care recipient month. It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: Recipient months are derived from the RG-23 and RB-24 Premiums Payable System reports generated from the Texas Department of Human Service's (TDH) eligibility files. For the more recent months of data, appropriate completion factors shall be applied in order to generate total incurrals.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected recipient months to be incurred.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 EF 09

Efficiency: 10 Average Children's Health Insurance Premium Per Recipient Month: Non-Managed Care

Short Definition: This measures is the average monthly premium paid per Children's Health Insurance Program non-Managed Care recipient month. It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Purpose/Importance: It reflects the amount paid to the health insuring agent for each recipient month incurred and reflects the estimated cost of all services covered under the insured arrangement.

Source/Collection of Data: Recipient months are derived from the RG-23 and RB-24 Premiums Payable System reports generated from the Texas Department of Human Service's (TDH) eligibility files. For the more recent months of data, appropriate completion factors shall be applied in order to generate total incurrals.

Method of Calculation: The average monthly premium is calculated by taking the total estimated dollar value of claims projected to be incurred for each type of client and dividing the total by the number of projected recipient months to be incurred. NOTE: Children's Health Insurance Program eligibles are children born before 10/1/83, up to age 19, whose family income is above Medically Needy and below 100% Federal Poverty Income Level (FPIL). Monthly premiums are determined by negotiations with the fee-for-service contractor (NHIC). The premiums consist of a pure premium rate combined with an administrative premium. For a quarterly or annual weighted average premium, sum the premium dollar amounts and recipient months for the given time period. The quarterly or annual weighted average premium rate is therefore equal to the total statewide dollar amounts for the time period divided by the total statewide recipient months for the time period.

Data Limitations: Where negotiations have not been concluded for a particular time period for a contractor, an estimate of the monthly average premium shall be prepared. Such an estimate shall be based Efficiency Measure Average Children's Health Insurance Premium per Recipient Month -- Non-Managed Care on statistical reports that depict claim cost and/or encounter information (the ST-750 report furnished by NHIC) and, where applicable, application of cost-of-living factors to historical premium rates.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 EF 10

Output: 01 Average Newborn Recipient Months Per Month: Managed Care

Short Definition: The average monthly number of recipient months for which a premium payment is made for newborn, managed care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months for which a premium payment is made for newborn, managed care recipients.

Source/Collection of Data: The RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, re-determinations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 OP 01

Output: 02 Average Newborn Recipient Months Per Month: Non-Managed Care

Short Definition: The average monthly number of recipient months of eligibility for which a premium payment is made for eligible non-managed care, newborn infants. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months of eligibility for which a premium payment is made for eligible non-managed care, newborn infants.

Source/Collection of Data: The monthly RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: Recipient months are accounted for under an incurred basis and the exposure period for each month is the current month plus an additional seven months to allow for corrections, re-determinations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 OP 02

Output: 03 Average Expansion Children Recipient Months Per Month: Managed Care

Short Definition: The average monthly number of recipient months for which a premium payment is made for expansion children, managed care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months for which a premium payment is made for expansion children, managed care recipients.

Source/Collection of Data: The RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, re-determinations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 OP 03

Output: 04 Average Expansion Children Recipient Months Per Month: Non-Managed Care

Short Definition: This measure is the average monthly number of recipient months for which a premium payment is made for non-managed care, expansion children recipients. A recipient month is defined as one month's coverage for an individual who has been determined eligible for Medicaid services under this program category.

Purpose/Importance: This measure is the average monthly number of recipient months for which a premium payment is made for non-managed care, expansion children recipients.

Source/Collection of Data: The monthly RG-23 and RG-24 from the Premiums Payable System.

Method of Calculation: Recipient months are accounted for under an incurred basis and the exposure period for each month is the current month plus an additional seven months to allow for corrections, re-determinations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 OP 04

Output: 05 Average Federal Mandate Children Recipient Months Per Month: Managed Care

Short Definition: The average monthly number of recipient months for which a premium payment is made for federal mandate children, managed care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months for which a premium payment is made for federal mandate children, managed care recipients.

Source/Collection of Data: The RG23 and RG24 reports from the Premiums Payable System.

Method of Calculation: Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, re-determinations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 OP 05

Output: 06 Average Federal Mandate Children Recipient Months Per Month: Non-Managed Care

Short Definition: This measure is the average monthly number of recipient months for which a premium payment is made for non-managed care, federal mandate children recipients. A recipient month is defined as one month's coverage for an individual who has been determined eligible for Medicaid services.

Purpose/Importance: This measure is the average monthly number of recipient months for which a premium payment is made for non-managed care, federal mandate children recipients.

Source/Collection of Data: The monthly RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: Recipient months are accounted for under an incurred basis and the exposure period for each month is the current month plus an additional seven months to allow for corrections, re-determinations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 OP 06

Output: 07 Average Medically Needy Recipient Months Per Month: Managed Care

Short Definition: The average monthly number of recipient months for which a premium payment is made for medically needy, managed care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid managed care services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months for which a premium payment is made for medically needy, managed care recipients.

Source/Collection of Data: The RG23 and RG 24 reports from the Premiums Payable System.

Method of Calculation: Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, re-determinations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 OP 07

Output: 08 Average Medically Needy Recipient Months Per Month: Non-Managed Care

Short Definition: The average monthly number of recipient months of eligibility for which a premium payment is made for non-managed care, medically needy recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months of eligibility for which a premium payment is made for non-managed care, medically needy recipients.

Source/Collection of Data: The monthly RG-23 and RG-24 report from the Premiums Payable System.

Method of Calculation: Recipient months are accounted for under an incurred basis and the exposure period for each month is the current month plus an additional seven months to allow for corrections, re-determinations, retroactive decisions, and post and prior eligibility periods.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 OP 08

Output: 09 Average Children's Health Insurance Premium Recipient Months Per Month: Managed Care

Short Definition: The average monthly number of recipient months for which a premium is made for Children's Health Insurance Program Managed Care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid Managed Care services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months for which a premium is made for Children's Health Insurance Program Managed Care recipients.

Source/Collection of Data: The Premiums Payable System reports (RG-23 and RG-24) by Texas Department of Human Services (TDHS).

Method of Calculation: Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, re-determinations, retroactive decisions, and post and prior eligibility periods. NOTE: Children's Health Insurance Program eligibles are children born before 10/1/83, up to age 19, who family income is above Medically Needy and below 100% Federal Poverty Income Level (FPIL). The quarterly average is the sum of the recipient months for the 3 months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months divided by the number of months summed.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 OP 09

Output: 10 Average Children's Health Insurance Premium Recipient Months Per Month: Non-Managed Care

Short Definition: The average monthly number of recipient months for which a premium is made for Children's Health Insurance Program non-Managed Care recipients. A recipient month is defined as one month's coverage for an individual who has been determined as eligible for Medicaid services covered under the insured arrangement.

Purpose/Importance: Measures the average monthly number of recipient months for which a premium is made for Children's Health Insurance Program non-Managed Care recipients.

Source/Collection of Data: The Premiums Payable System reports (RG-23 and RG-24) by Texas Department of Human Services (TDHS).

Method of Calculation: Recipient months are accounted for under an incurred basis, and the exposure period for each month is the current month plus an additional seven months to allow for corrections, re-determinations, retroactive decisions, and post and prior eligibility periods. Note: Federal Mandate Children Ages 15-18 are children born before 10/1/83, up to age 19, who family income is above Medically Needy and below 100% Federal Poverty Income Level (FPIL). The quarterly average is the sum of the recipient months for the 3 months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months divided by the number of months summed.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 02 - 01 - 04 OP 10

Strategy: 02-01-05 Medicare Payments

Efficiency: 01 Average SMIB Premium Per Month

Short Definition: The average monthly premium paid for SMIB Part B premium for Medicare eligible Medicaid clients. The SMIB Part B premium is set by the Social Security Administration and is effective for each calendar year.

Purpose/Importance: TDH pays the Social Security Administration a premium for coverage of physician and other related services.

Source/Collection of Data: Social Security Act and TDHS report MF232-01.

Method of Calculation: The average is calculated by taking the total estimated dollar value of claims projected to be incurred for this type of client and dividing the total by the number of projected recipient months to be incurred. The SMIB Part B premium is set by the Social Security Administrations and is effective for each calendar year.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 05 EF 01

Efficiency: 02 Average Part A Premium Per Month

Short Definition: The average monthly premium paid for Medicare Part A coverage for Medicare eligible Medicaid clients. The Medicare Part A premium is set by the Social Security Administration and is effective for each calendar year.

Purpose/Importance: TDH pays the Social Security Administration a premium for coverage of physician and other related services.

Source/Collection of Data: Social Security Act and TDHS report MF832-01.

Method of Calculation: The average is calculated by taking the total estimated dollar value of claims projected to be incurred by clients and dividing this total by the number of projected recipient months to be incurred. The numerator will be the sum of full and reduced rate Part A dollars; the denominator will be the sum of full and reduced rate Part A recipient months. The Medicare Part A premium is set by the Social Security Administration and is effective for each calendar year.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 05 EF 02

Efficiency: 03 Average Qualified Medicare Beneficiaries (QMB) Cost Per Month

Short Definition: This measure is the average monthly cost for the payment of deductible and coinsurance benefits for Medicare eligible Medicaid clients.

Purpose/Importance: This measure is the average monthly cost for the payment of deductible and coinsurance benefits for Medicare eligible Medicaid clients.

Source/Collection of Data: The monthly RG-23 and RG-24 reports from the Premiums Payable System and monthly billing vouchers submitted for payment by the Medicaid contractor.

Method of Calculation: The calculation is made by taking the total yearly deductible and coinsurance payments paid and dividing this by the total monthly number of eligible QMBs for the year.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 05 EF 03

Output: 01 Supplemental Medical Insurance Part B (SMIB) Recipient Months Per Month

Short Definition: The average monthly number of recipient months of eligibility for which a premium payment is made for supplemental medical insurance benefits (SMIB) Part B coverage.

Purpose/Importance: TDH pays the Social Security Administration a premium for Medicare Part B coverage for Qualified Medicare Beneficiaries (QMB), which covers physician and other related services.

Source/Collection of Data: Monthly MF-232 report, which provides the number of eligibles for each month on an incurred basis.

Method of Calculation: The quarterly average is the sum of the recipient months for the 3 months in the specified quarter divided by 3. The year-to-date average is the sum of the monthly recipient months divided by the number of months summed.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 05 OP 01

Output: 02 Part A: Recipient Months Per Month

Short Definition: The average monthly number of Medicare eligible recipients for which a Medicare Part A premium is paid. TDH pays the Social Security Administration a premium for Part A coverage for Qualified Medicare Beneficiaries (QMB) and Medicaid Qualified Medicare Beneficiaries (MQMB). The premium covers hospitalizations and other related services. Purpose/Importance: TDH pays the Social Security Administration a premium for Part A coverage for Qualified Medicare Beneficiaries (QMB) and Medicaid Qualified Medicare Beneficiaries (MQMB). The premium covers hospitalizations and other related services.

Source/Collection of Data: Monthly MF-832 report, which provides the number of eligibles for each month on an incurred basis.

Method of Calculation: The quarterly average is the sum of the recipient months for the 3 months in the specified quarter divided by 3. The year-to- date average is the sum of the monthly recipient months divided by the number of months summed.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 05 OP 02

Output: 03 Number Of Qualified Medicare Beneficiaries (QMBs)

Short Definition: This measure is the average monthly number of Medicare eligible Medicaid clients who meet the criteria established by federal legislation

Purpose/Importance: TDH is required to pay Medicare premiums, deductibles, and coinsurance liabilities for QMBs whose income is at or below certain eligibility criteria. These clients are not eligible for other Title XIX services.

Source/Collection of Data: The monthly RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: The quarterly average is the sum of the recipient months for the 3 months in the specified quarter divided by 3. The year to date average is the sum of the monthly recipient months divided by the number of months summed.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 05 OP 03

Strategy: 02-01-06 EPSDT-Comprehensive Care

Efficiency: 01 Average Cost Of Clients Receiving Extended Benefits Through EPSDT-CCP

Short Definition: This measure is the average dollar amount spent on a client receiving EPSDT-CCP program benefits.

Purpose/Importance: This measure is the average dollar amount spent on a client receiving EPSDT-CCP program benefits.

Source/Collection of Data: HMPR 630K report, the ST650, and monthly billing vouchers submitted for payment by the Medicaid contractor.

Method of Calculation: The calculation is made by taking the total EPSDT-CCP incurred expenditures and dividing this by the total number of Medicaid eligible children receiving EPSDT-CCP services.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 06 EF 01

Output: 01 Number Of Clients Receiving Extended Benefits Through EPSDT-CCP

Short Definition: The number of clients under the age of 21 who received EPSDT-CCP services.

Purpose/Importance: Federal legislation required states to provide diagnostic/ treatment services for conditions identified through an EPSDT screen or other health care encounter but not covered or provided under the State Medicaid Plan. Such services must be federally allowable Medicaid services.

Source/Collection of Data: HMPR 630k report generated by the Medicaid Insuring Agent.

Method of Calculation: The number of clients under the age of 21 who received EPSDT-CCP services.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference: AGY 501 076 - R 02 - 01 - 06 OP 01

Strategy: 02-01-07 Cost Reimbursed Services

Efficiency: 01 Average Undocumented Alien Cost Per Month

Short Definition: The average monthly costs of providing Medicaid to undocumented aliens residing illegally in the U.S., who are in need of medical services due to an emergency condition.

Purpose/Importance: Captures the average monthly costs of providing Medicaid to undocumented aliens residing illegally in the U.S., who are in need of medical services due to an emergency condition.

Source/Collection of Data: The monthly RG-23 and RG-24 reports from the Premiums Payable System and monthly billing vouchers submitted for payment by the Medicaid Contractor.

Method of Calculation: The total expenditures incurred are divided by the average monthly number of eligible clients.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 07 EF 01

Output : 01 Number Of Enrolled Federally Qualified Health Centers

Short Definition: The average total Number of Enrolled Federally Qualified Health Centers (FQHCs) in the Medicaid program is the average number of FQHCs and FQHC look-alikes that are actively participating in providing services to clients.

Purpose/Importance: An FQHC's enrollment in the Texas Medicaid Program is contingent upon receiving one of the grants available under the Public Health Service Act or upon being designated by the U.S. Department of Human Services to receive one of these grants, according enrollment guidelines for the Texas Medicaid Program. An FQHC look-alike meets all the requirements to receive one of the grants under the Public Health Service Act but does not actually receive any of these grants, according to FQHC status qualification guidelines from the National Heritage Insurance Company.

Source/Collection of Data: The current data source is the MSB93091, a mainframe report generated by the Texas Health and Human Services Commission using the "Stat File". In the future the data source will be Vision 21 from the Ad Hoc Query Platform, which will be managed by the Texas Department of Human Services. The Medicaid Contractor's Provider Enrollment Agreement provides information to the database.

Method of Calculation: The quarterly average for number of enrolled FQHCs is the sum of the number of actively participating FQHCs and FQHC look-alikes for each month in the three month period divided by three. The year-to-date average for number of enrolled FQHCs is the sum of the number of actively participating FQHCs and FQHC look-alike for each month in the given period divided by the total number of months in that period.

Data Limitations: The Health Care Financing (HCF) budget staff provides the HCF Budget Director with data used in computing measures. This information is reviewed by the HCF Budget Director prior to submission to the Bureau Chief and Associate Commissioner for HCF.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 07 OP 01

Output: 02 Number Of Undocumented Aliens Served

Short Definition: The average monthly number of undocumented aliens provided Medicaid services. This measure reflects the number of undocumented aliens residing illegally in the U.S. who have an emergency medical condition and meet all Medicaid eligibility criteria.

Purpose/Importance: This measure reflects the number of undocumented aliens residing illegally in the U.S. who have an emergency medical condition and meet all Medicaid eligibility criteria.

Source/Collection of Data: Monthly RG-23 and RG-24 reports from the Premiums Payable System.

Method of Calculation: The total expenditures incurred is divided by the average monthly number of eligible clients.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 07 OP 02

Strategy: 02-01-08 Vendor Drug Program

Efficiency: 01 Average Cost Per Prescription

Short Definition: This measure is the total prescription cost incurred divided by the total number of prescriptions incurred per year.

Purpose/Importance: Captures the total prescription cost incurred divided by the total number of prescriptions incurred per year.

Source/Collection of Data: State office computer report MH492 and MH493.

Method of Calculation: The total prescription cost incurred divided by the total number of prescriptions incurred per year.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 08 EF 01

Efficiency 02: Net Aged, Blind, and Disabled Average Monthly Prescription Drug Cost Per Recipient Month

Short Definition: The average monthly cost of prescription drugs less manufacturer drug rebates per Medicaid eligible Aged, Blind and Disabled (ABD) recipient month. This measure defines the costs of providing prescription drug services to Medicaid eligible ABD clients in a format that facilitates comparison to other prescription drug programs in other agencies, health care organizations, and insurance plans.

Purpose/Importance: Different types of clients have different health needs and cost characteristics so it is important to separate drug costs by type of client in order to obtain accurate comparison results. Prescription drug programs in other organizations have different drug coverage policies and receive different levels of drug price discounts and drug manufacturer rebates, so it is important to provide measures that take the costs of drug coverage policies, price discounts and manufacturer rebates into consideration.

Source/Collection of Data: Health Care Financing/TDHS monthly computer reports (MH 492 and MH 493) used for actuarial cost data collection/projection, and monthly Fiscal drug rebate deposit reports.

Method of Calculation: An average is obtained by dividing ABD Vendor Drug dollar costs (summed), less drug manufacturer rebates, by the number of ABD eligible recipient months (summed) for the appropriate number of months.

Data Limitations: Claims/cost data from the MH 492 and MH 493 is on an incurred basis. Data for the drug rebates is on a cash basis.

Calculation Type: Non-cumulative.

New Measure: Yes.

Desired Performance: Lower than target.

Cross Reference to Prior Biennium: None

Efficiency: 02 Net Temporary Aid to Needy Families (TANF) Average Monthly Prescription Drug Cost Per Recipient Month

Short Definition: The average monthly cost of prescription drugs less manufacturer drug rebates per TANF recipient month. This measure defines the costs of providing prescription drug services to Medicaid eligible TANF clients in a format that facilitates comparison to other prescription drug programs in other agencies, health care organizations, and insurance plans.

Purpose/Importance: Different types of clients have different health needs and cost characteristics so it is important to separate drug costs by type of client in order to obtain accurate comparison results. Prescription drug programs in other organizations have different drug coverage policies and receive different levels of drug price discounts and drug manufacturer rebates, so it is important to provide measures that take the costs of drug coverage policies, price discounts and manufacturer rebates into consideration.

Source/Collection of Data: Health Care Financing/TDHS monthly computer reports (MH 492 and MH 493) used for actuarial cost data collection/projection, and monthly Fiscal drug rebate deposit reports.

Method of Calculation: An average is obtained by dividing TANF Vendor Drug dollar costs (summed), less drug manufacturer rebates, by the number of TANF eligible recipient months (summed) for the appropriate number of months.

Data Limitations: Claims/cost data from the MH 492 and MH 493 is on an incurred basis. Data for the drug rebates is on a cash basis.

Calculation Type: Non-cumulative.

New Measure: Yes

Desired Performance: Lower than target

Cross Reference to Prior Biennium: None

Efficiency: 03 Net All Clients Average Monthly Prescription Drug Cost Per Recipient Month

Short Definition: The average monthly cost of prescription drugs less manufacturer drug rebates per all Medicaid eligible clients recipient month. This measure defines the costs of providing prescription drug services to all Medicaid eligible clients in a format that facilitates comparison to other prescription drug programs in other agencies, health care organizations, and insurance plans.

Purpose/Importance: Different types of clients have different health needs and cost characteristics so it is important to separate drug costs by type of client in order to obtain accurate comparison results. Prescription drug programs in other organizations have different drug coverage policies and receive different levels of drug price discounts and drug manufacturer rebates, so it is important to provide measures that take the costs of drug coverage policies, price discounts and manufacturer rebates into consideration.

Source/Collection of Data: Health Care Financing/TDHS monthly computer reports (MH 492 and MH 493) used for actuarial cost data collection/projection, and monthly Fiscal drug rebate deposit reports.

Method of Calculation: An average is obtained by dividing All Clients Vendor Drug dollar costs (summed), less drug manufacturer rebates, by the number of All Clients eligible recipient months (summed) for the appropriate number of months.

Data Limitations: Claims/cost data from the MH 492 and MH 493 is on an incurred basis. Data for the drug rebates is on a cash basis.

Calculation Type: Non-cumulative.

New Measure: Yes.

Desired Performance: Lower than target.

Cross Reference to Prior Biennium: None

Output: 01 Annual Medicaid Prescriptions Incurred

Short Definition: This measure reports the number of prescriptions incurred for payment per year.

Purpose/Importance: This measure reports the number of prescriptions incurred for payment per year.

Source/Collection of Data: Computer print-out MH492 and MH493.

Method of Calculation: Annual Medicaid Prescriptions = the number of prescriptions incurred for payment in a year's time.

Data Limitations: None

Calculation Type: Cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 08 OP 01

Output: 02 Number Of Contracted Pharmacy Providers

Short Definition: This measure reports the average number of providers per month.

Purpose/Importance: This measure reports the average number of providers per month.

Source/Collection of Data: MH432-01 Report (Active Vendor Listing) from TDHS and Vendor Drug Program staff compilations.

Method of Calculation: The quarterly average number of contracted pharmacy providers is the sum of the contracted pharmacy provider counts for the 3 months in the specified quarter divided by 3. The year to date average number of contracted pharmacy providers is the sum of the monthly counts of these providers divided by the number of months summed.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 08 OP 02

Output: 03 Prescriptions Incurred Per Recipient Per Month

Short Definition: This measure is the average number of prescriptions incurred per month divided by the average number of unduplicated recipients per month of paid claims data.

Purpose/Importance: This measure is the average number of prescriptions incurred per month divided by the average number of unduplicated recipients per month of paid claims data.

Source/Collection of Data: Computed manually based on data from MH492 and MH493.

Method of Calculation: This measure is the average number of prescriptions incurred per month divided by the average number of unduplicated recipients per month of paid claims data.

Data Limitations: None

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference To Prior Biennium: AGY 501 076 - R 02 - 01 - 08 OP 03

Strategy: 02-01-10 Medically Dependent Children Waiver

Efficiency: 01 MDCP average monthly cost per client per month

Short Definition: This efficiency measure shows the average Medically Dependent Children Program (MDCP) waiver services expenditure per client per month.

Purpose/Importance: It provides information on waiver service utilization trends and insight into the flow of client services dollars.

Source/Collection of Data: The MDCP database is the source for both the waiver services expenditure data and the monthly client count. The MDCP database is maintained by the MDCP staff in the Central Office of the Texas Department of Human Services.

Method of Calculation: The data is collected by: a) identifying each unique served client who received a paid waiver service for the month ("served client"), and b) by identifying all paid claims for those served clients in that month. Clients are not included in this count if there is no paid claim for the month. The average monthly cost for waiver services is derived by adding the cost per client for each month in the reporting period and dividing by the number of months in the reporting period.

Data Limitations: Providers have 95 days from the date of service to submit a claim. Consequently, the data for any given quarter cannot be considered complete until adequate time has passed from the last day of the quarter. Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data. The data does not reflect all dimensions of service utilization/delivery – it does not provide information on services delivered for which claims were never submitted not does it reflect those claims submitted after the cut-off date and for which no payment will be made.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Biennium: AGY 501 076 - R 04 - 01 - 03 EF 01

Output: 01 MDCP clients per month

Short Definition: This output measure shows the average number of clients receiving paid waiver services (i.e., served clients) in the Medically Dependent Children Program (MDCP) during the month.

Purpose/Importance: It provides information related to achieving client participation goals and in monitoring budget projections. Excluded from the measures are children who are still in the eligibility determination process, children for whom it was determined they are not eligible for the MDCP, and those children who are enrolled participants, but who did not receive a paid waiver service in that particular month.

Source/Collection of Data: The MDCP database is the source for this data. This database is maintained by MDCP program staff at the Texas Department of Human Services Central Office. The data is collected by identifying each unique client who received a paid waiver service for the month (ie: served client") in question.

Method of Calculation: The average count of served clients is achieved by adding the number of served clients in each month of the reporting period then dividing that number by the number of months in the reporting period.

Data Limitations: Providers have 95 days from the date of the service to submit a claim. Consequently, the data for any given quarter cannot be considered complete until adequate time has passed from the last day of the quarter. Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

Cross Reference to Prior Biennium： AGY 501 076-R 04-01-03 OP 01

Strategy: 02-01-11 Texas Health Steps (EPSDT) Medical

Efficiency: 01 Average cost per THS (EPSDT) client receiving medical screens in fee for service Medicaid

Short Definition: This measure reports the Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) funds expanded for THS (EPSDT) paid medical screens divided by the unduplicated number of clients receiving medical screens from the THS (EPSDT) medical program in Traditional (fee for service) Medicaid.

Purpose/Importance: This measure reports the Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) funds expanded for THS (EPSDT) paid medical screens divided by the unduplicated number of clients receiving medical screens from the THS (EPSDT) medical program in Traditional (fee for service) Medicaid.

Source/Collection of Data: The data source is the HMPR980K report generated National Heritage Insurance Company Report (NHIC), Texas Department of Health (TDH) Accounting System.

Method of Calculation: This measure reports the Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) funds expanded for THS (EPSDT) paid medical screens divided by the unduplicated number of clients receiving medical screens from the THS (EPSDT) medical program in Traditional (fee for service) Medicaid. This measure includes the cost of medical screens and excludes case management claims reimbursed by the Medicaid Claims Contractor, laboratory fees, hearing aid services, vaccine purchases (if any), TB antigens/syringes, and newborn genetic blood testing. The cost of medical screens provided through Medicaid Managed Care is excluded from this measure.

Data Limitations: Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data. Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 04 - 02 - 01 EF 01

Efficiency: 02 Average cost per THS (EPSDT) medical screen performed in fee for service Medicaid

Short Definition: This measure reports the Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) funds expended for THS (EPSDT) paid total medical screens divided by the total number of THS (EPSDT) paid medical screens in Traditional (fee for service) Medicaid.

Purpose/Importance: This measure reports the Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) funds expended for THS (EPSDT) paid total medical screens divided by the total number of THS (EPSDT) paid medical screens in Traditional (fee for service) Medicaid.

Source/Collection of Data: The data source is the HMPR980K report generated National Heritage Insurance Company Report (NHIC), Texas Department of Health (TDH) Accounting System.

Method of Calculation: This measure includes the cost of medical claims reimbursed by Medicaid Claims Contractor. Medicaid Managed Care, ancillary costs, and medical case management data are excluded from this measure.

Data Limitations: Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data. Other automated systems may replace the current systems. The data

from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 04 - 02 - 01 EF 02

Output: 01 Number of THS (EPSDT) medical screens performed in fee for service-Medicaid

Short Definition: This measure reports the number of medical screens performed in Traditional (fee for service) during the state fiscal year and paid for by Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT).

Purpose/Importance: This measure reports the number of medical screens performed in Traditional (fee for service) during the state fiscal year and paid for by Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT).

Source/Collection of Data: The data source is HMPR980K report generated by National Heritage Insurance Company Report (NHIC).

Method of Calculation: This measure includes the number of medical check-ups and exceptions to periodicity. This measure excludes screens performed in Medicaid Managed Care arrangements.

Data Limitations: Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data. Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

Cross Reference to Prior Biennium: AGY 501 076 - R 04 - 02 - 01 OP 01

Output: 02 Number of newborns receiving hearing screens

Short Definition: The number of newborns receiving a newborn hearing screen (NBHS), as mandated under Section 1, Subtitle B, Title 2, Health and Safety Code, Chapter 47, at a fully implemented NBHS birthing facility will be reported.

Purpose/Importance: The number of newborns receiving a newborn hearing screen (NBHS), as mandated under Section 1, Subtitle B, Title 2, Health and Safety Code, Chapter 47, at a fully implemented NBHS birthing facility will be reported.

Source/Collection of Data: The data source is the TDH Newborn Hearing Screening (NBHS) System. Fully implemented NBHS birthing facility means that a birthing facility, either a hospital or birthing center, is meeting the NBHS certification criteria set by the Texas Department of Health (TDH). Data will include only those newborns receiving a NBHS. The number of newborns receiving a newborn hearing screen (NBHS) at a fully implemented NBHS birthing facility will be

reported. Data will include all newborns receiving a NBHS from fully implemented NBHS birthing facilities.

Method of Calculation: Newborns receiving a NBHS from NBHS birthing facilities that are not fully implemented will not be counted. Because NBHS will be phased in over time, the number of birthing facilities included in each report will change as more NBHS birthing facilities become fully implemented. It is anticipated that all NBHS birthing facilities will be fully implemented by August 31, 2001. The number of facilities included in each report will change as more NBHS birthing facilities become fully implemented; it is anticipated that all NBHS birthing facilities will be fully implemented by August 31, 2001. All Medicaid contracting birthing facilities must provide the NBHS and report their data to TDH. Non-Medicaid birthing facilities, hospitals or birthing centers with at least 100 births per year, licensed under either Chapter 241 or Chapter 244, HRC, that are in counties with a population of at least 50,000 must also report.

Data Limitations: Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data. Non-Medicaid birthing facilities licensed under Chapters 241 or 244, HRC, that are located in counties with populations under 50,000 may elect to participate in the NBHS program. Those facilities electing to participate must also report. The volume of screens performed by the latter group of facilities will be small.

Calculation Type: Cumulative

New Measure: No

Desired Performance: Higher than target

Cross Reference to Prior Biennium: AGY 501 076 - R 04 - 02 - 01 OP 05

Strategy: 02-01-12 Texas Health Steps (EPSDT) Dental

Efficiency: 01 Average cost per THS (EPSDT) dental client

Short Definition: This is the average cost per Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental client receiving THS (EPSDT) dental services during the state fiscal year.

Purpose/Importance: Measures the average cost per THS (EPSDT) dental client.

Source/Collection of Data: The data source is the HMPR 980K report generated by National Heritage Insurance Company (NHIC); Texas Department of Health (TDH) Accounting System. Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

Method of Calculation: This cost is calculated by dividing the total client dental services funds paid by the unduplicated number of THS (EPSDT) clients receiving at least one THS (EPSDT) paid dental service. Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data.

Data Limitations: A limitation is that providers have 90 days in which to submit a claim after the date of service, and if a claim is denied, the provider has 180 days in which to appeal; therefore, all claims for a reporting period may not have been processed at the time of reporting.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 04 - 02 - 02 EF 01

Efficiency: 02 Average cost per THS (EPSDT) orthodontic client

Short Definition: This is the average cost per Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) orthodontic client receiving THS (EPSDT) orthodontic services during the state fiscal year.

Purpose/Importance: Measures the average cost per THS (EPDST) orthodontic client.

Source/Collection of Data: The data source is the HMPR 980K report generated by National Heritage Insurance Company (NHIC); Texas Department of Health (TDH) Accounting System. Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

Method of Calculation: This cost is calculated by dividing the total client orthodontic services funds paid by the unduplicated number of THS (EPSDT) clients receiving a least one THS (EPSDT) orthodontic service. This measure excludes funds and service counts for dental services.

Data Limitations: A limitation is that providers have 90 days in which to submit a claim after the date of service, and if a claim is denied, the provider has 180 days in which to appeal; therefore, all claims for a reporting period may not have been processed at the time of reporting. Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Lower than target

Cross Reference to Prior Biennium: AGY 501 076 - R 04 - 02 - 02 EF 02

Output: 01 Number of THS (EPSDT) dental clients served

Short Definition: This is an unduplicated count of the number of Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental clients who received at least one THS (EPSDT) paid dental service during the state fiscal year.

Purpose/Importance: Measures the number of THS (EPSDT) dental clients served.

Source/Collection of Data: The data source is the HMPR 980K report generated by National Heritage Insurance Company (NHIC). Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

Method of Calculation: This is an unduplicated count of the number of Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental clients who received at least one THS (EPSDT) paid dental service during the state fiscal year.

Data Limitations: Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data. A limitation is that providers have 90 days in which to submit a claim after the date of service, and if a claim is denied, the provider has 180 days in which to appeal; therefore, all claims for a reporting period may not have been processed at the time of reporting.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

Cross Reference to Prior Biennium: AGY 501 076 - R 04 - 02 - 02 OP 01

Output: 02 Number of THS (EPSDT) active dental providers

Short Definition: This is an unduplicated count of the number of Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental providers who have provided paid dental services to at least one THS (EPSDT) Medicaid eligible client during the state fiscal year.

Purpose/Importance: Measures the number of THS (EPSDT) active dental providers.

Source/Collection of Data: The data source is HMPL 351k generated by National Heritage Insurance Company (NHIC). Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

Method of Calculation: This is an unduplicated count of the number of Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) dental providers who have provided paid dental services to at least one THS (EPSDT) Medicaid eligible client during the state fiscal year.

Data Limitations: There are several limitations. The data reported only reflects that number of dentists who have provided dental services. This does not measure access to dental services across the state. Providers have 90 days in which to submit a claim after the date of service and if a claim is denied the provider has 180 days in which to appeal; therefore, all claims for a reporting period may not have been processed at the time of reporting. Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

Cross Reference to Prior Biennium: AGY 501 076 - R 04 - 02 - 02 OP 02

Output: 03 Number of THS (EPSDT) orthodontic clients served

Short Definition: This is an unduplicated count of the number of Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) clients who received at least one paid orthodontic service during the state fiscal year.

Purpose/Importance: Measures the number of THS(EPSDT) orthodontic clients served.

Source/Collection of Data: The data source is the HMPR 980K report generated by National Heritage Insurance Company (NHIC). Other automated systems may replace the current systems. The data from these new systems may be combined with current systems and/or replace the data from the current systems. Specific data source used will be noted in supporting documentation.

Method of Calculation: This is an unduplicated count of the number of Texas Health Steps (THS), Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) clients who received at least one paid orthodontic service during the state fiscal year.

Data Limitations: A limitation is that providers have 90 days in which to submit a claim after the date of service, and if a claim is denied, the provider has 180 days in which to appeal; therefore, all claims for a reporting period may not have been processed at the time of reporting. Complete data may not be available for the reporting period at the time the report is due; therefore, projections may be included based on available data.

Calculation Type: Non-cumulative

New Measure: No

Desired Performance: Higher than target

Cross Reference to Prior Biennium: AGY 501 076 - R 04 - 02 - 02 OP 03